Mental Hospitals

MARCH 1955
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Awaiting patients coming through the cafeteria line at Northampton (Mass.) State Hospital, the attractively garnished smorgasbrod tables offer a pleasing variety of salads and other meal accompaniments.

In this issue:

THORAZINE*

to control

ATTACKS OF MANIA

On administration of 'Thorazine', "attacks of mania with accompanying elation, overactivity and delusions of grandeur subside rather promptly . . . This alone represents a therapeutic advance since mania often resists shock therapies and is a very exhausting condition for the patient, relatives and hospital staff."

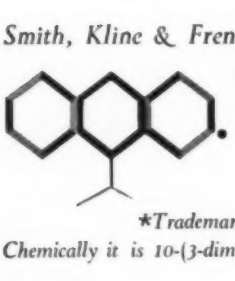
Kinross-Wright, V.: Postgrad. Med. 16:297 (Oct.) 1954.

'Thorazine' Hydrochloride is available in 10 mg., 25 mg., 50 mg., and 100 mg. tablets; 25 mg. (1 cc.) ampuls and 50 mg. (2 cc.) ampuls; and syrup (10 mg./5 cc.).

Information on 'Thorazine' is available on request.

Smith, Kline & French Laboratories

1530 Spring Garden St., Philadelphia 1



**Trademark for S.K.F.'s brand of chlorpromazine.*
Chemically it is 10-(3-dimethylaminopropyl)-2-chlorphenothiazine.

THIS MONTH'S COVER

The smorgasbord, or salad table, has proven a popular mealtime feature for ambulant patients in Massachusetts state hospitals. The idea was originated a few years ago by Mr. Frank W. Smith, Steward of the Northampton State Hospital. It has since been adopted by many of the other state institutions.

At Northampton, where the plan is particularly popular, two smorgasbord tables are set up in each cafeteria. They measure 8 by 3 feet and are placed so that patients can serve themselves from all sides. Ample room is allowed for them to rest their trays on the table while making selections.

The smorgasbord items are planned daily by the dietitians to supplement the regular menu, which is complete in itself. If the main course is roast turkey, for example, the salad table might hold cranberry sauce, celery, cottage cheese and relishes. Other favored items include salads of all types—vegetable, macaroni, jello, cole slaw, etc.—potato chips, deviled eggs, sliced tomatoes, cheeses and pickles. Very little cost is involved, since most of the items use produce from the hospital farm. Mr. Smith says that suitable leftover foods, such as puddings, cakes and cold meats, can also be used to advantage on the tables.

Condiments are kept on the tables, rather than on the cafeteria counter where they slowed service. At breakfast the table holds jams, jellies and marmalades.

During noon and evening meals a cafeteria girl is in charge of the tables to see that the dishes are kept filled and the tables tidy. This assignment is made on a rotating basis by the dietitian so that each girl has a turn. The cafeteria girl makes the salads, with the help of the vegetable preparation man. The salad dishes are made of stainless steel in various sizes and shapes; they are attractively arranged on the tables, which are covered with white tablecloths.

The smorgasbord is intended primarily to add variety to the regular basic diet served on the cafeteria line. It also enables patients who do not care for certain of the menu items to substitute foods from the smorgasbord table.

Last spring Mr. Smith was commended for this plan by the hospital's Board of Trustees, who incorporated an endorsing statement into the minutes of one of their meetings, and by the hospital superintendent, Dr. Fernand Longpré. Dr. Longpré's commendation noted that the smorgasbord gave the patients "the feeling that we have confidence in them by giving them the opportunity to make their own selections with practically no supervision."

"Salad tables of this type could be used in any institutional cafeteria," Mr. Smith says. "All one needs is a table, tablecloth or other suitable covering, salad dishes and an interest in the plan's success—and the last requisite is very important."

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CONTENTS:

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Convalescent Program Paves the Way for Successful Community Adjustment

By H. B. WITTEN, M.D., *Superintendent*
Central State Griffin Memorial Hospital
Norman, Oklahoma

Recovery from acute or chronic mental illness, no less than recovery from a debilitating physical ailment, requires a period of convalescence. A so-called chronic patient who recovers after many years of hospitalization needs to be re-acquainted with the aspects of normal life that are missing from a primarily custodial situation. For the patient recovering from an acute psychotic episode, an atmosphere must be established wherein the rigid controls of the Acute Treatment Service may be gradually relinquished. Patients of both types, while differing somewhat in their specific needs in a convalescent program, benefit greatly from a program tailored to strengthen their recuperative powers and enable them eventually to resume personal responsibility.

As sufficient self-controls and judgment values return to these patients, the resolution of neurotic residuals and emotional problems becomes important. Thus, a comprehensive convalescent program is designed to provide a neutral emotional atmosphere, one in which personal and group therapy can be continued as long as needed. Old established dependency strivings must be replaced with new goals of mature independence.

The program should help the newly recovered psychotic patient to consolidate and strengthen his recently acquired ego reintegration. It must provide him with a series of successful living experiences. Sufficient time should be taken to test and prove his ability to resume normal responsibilities, including the exercise of emotional controls and social judgment.

Programming for Special Needs

The Convalescent Service at our hospital was established in 1953 during an overall hospital reorganization. (See MENTAL HOSPITALS, June 1954, page 7.) As the result of a staffing study, each of the hospital services was structured about a functional and philosophical conception of needed services. The Convalescent Service was designed to aid the rehabilitation not only of patients recovering from acute psychotic episodes, but also of those who had been hospitalized for a longer period. Many of these who were fortunate enough to undergo a spontaneous remission were unfortunate enough to be trapped on back wards. They were, as a result, consumed by a pathological "institutionalization," characterized by increasing dependency and social inadequacy and resulting in despair and hopelessness. This became as destructive as had been their psychotic episode, and led to habit and personality dilapidation. Thus it was evident that the Convalescent Service would have to help these patients overcome the deteriorating effects of years of custodial existence.

Art therapy is one of the means by which newly recovered patients' creative energies are constructively utilized at Central State Griffin Memorial Hospital. Philadelphia (Pa.) State Hospital, where this picture was taken, also uses art therapy to aid the recovery process.

The purpose of the Convalescent Service is to understand the patient's psychopathology and to use a variety of therapeutic techniques dynamically suited to his needs. Both the men and the women are on open wards and live under patient government. Their daily regimen includes individual and group therapy, and participation in ancillary therapy activities according to their talents and desires. From this service the patients are discharged back to the community.

Serving Others Encouraged

The program is a comprehensive one in which the patient's needs are met sufficiently so that he can be encouraged to serve others rather than to remain in need of intensive personal attention. We have found that patients who have recently undergone a remission of their psychosis exhibit a notable enthusiasm for assisting other patients. Their creative energies

are constructively utilized through participation in occupational, recreational, music, art, biblio-therapy and the other ancillary therapies. The achievement of positive motivation and successful self-controls allows these patients to place themselves at the service of other patients. This leads them to an acceptance of their own recent illness and, at the same time, provides them with a rich and pleasurable living experience. By serving others in a self-satisfying way, the patient on the Convalescent Service regains self-realization and an increasing self-respect which provide him with new ego strength. This return of self-esteem, enhanced by the acquisition of new-found ego controls, seems to enable these patients to live a productive and relatively anxiety-free life. Thus they help to create a therapeutic milieu for those patients newly admitted to the Convalescent Service.

At present, on the Convalescent Service, the process of self-discovery and rehabilitation is aided by the patient government system. The patients elect an administrative body to direct ward management, and discipline and controls are self-imposed by the vote of the rest of the group. The patients themselves are responsible for their own selection of an occupational assignment, for attending therapy sessions, attending to housekeeping duties, getting to meals, participation in group activities, and for all other aspects of their daily life that require personal initiative. In this way, through the assumption of leadership and gradually increasing responsibilities, these patients are being prepared for their return to the obligations of home and community.

Home-like Atmosphere Created

A desire for resuming home life is fostered in several ways. The ward is made as pleasant and home-like as possible, with curtained windows, rugs, pictures on the walls, and telephone service. Good grooming is emphasized. The patients wear their own personal clothing and are responsible for the care of it, as for all personal property. Their personal funds are theirs to spend as they see fit, in keeping with the aim of the Convalescent Service to affirm respect for the dignity of the individual. Entertainment on these wards includes television, music and games. Normal courteous friendliness between men and women is encouraged.

Leisure time activities on the convalescent ward at Dr. Witten's hospital include music, games and television, such as are shown in the above picture taken at California's Metropolitan State Hospital. The Oklahoma hospital likewise encourages normal courteous friendliness between men and women patients in their convalescent program.

These patients may obtain off-grounds passes to go to town to do their own shopping or banking, to attend the theater, and for similar purposes. Such excursions, we feel, help condition the patient to exercise independent judgment in a competitive society.

As self-confidence returns, especially in those patients on the Convalescent Service who are taking the long, slow road back after years of hospitalization—and this process may take as much time as necessary—the pleasure of living is enhanced in every way possible, and the patient is carefully protected from failure. It is a truism that nothing succeeds like success, and this applies particularly to the newly recovered psychotic. It is equally true that to such a patient nothing is as disastrous as failure, even a small one. Thus he must be allowed to assume responsibilities in accordance with his capacities. Progress is gauged by increasing insight and soundness of judgment, as well as by his willingness to accept responsibility.

As ego strength returns and ego functions become better integrated, the patient is allowed a series of increasingly prolonged visits to his home. Since the home atmosphere is frequently charged with emotion on these occasions, the Social Service department paves the way by helping the family resolve irrational fears and other possibly harmful reactions to the patient.

Above all, residence on the Convalescent Service should reinforce the patient's self-value as a person worthy of being loved. It should also ensure his acceptance in the family constellation when he is ready to return home. If the original family or social unit no longer exists, a new one should be secured before the patient is discharged. He must feel that all is well within himself and that the Convalescent Service has provided him with a way back to the life he so desires.

A persevering staff of many disciplines has demonstrated that not only can mental illness be successfully treated, but that permanence of recovery is influenced by a convalescent program of sufficient duration to give the patient confidence in his ability to make a successful transition from hospital to community life.

THE PATIENT DAY BY DAY

PURPOSEFUL WORK AIDS MENTAL PATIENTS

By PETER BARRY, *Laundry Manager New Hampshire State Hospital, Concord*

Two of our most trusted employees in the laundry of this hospital are recovered patients. One of them was an insurance man before his illness, and he has since told me that while he was sick, the one thing on his mind was. "Will I ever be able to do a day's work again like other men?"

When he was a patient he worked in our laundry under the Industrial Therapy program. He told me that when he got so he could keep up with the regular laundry machine operators, it was the happiest day of his life.

After forty years of service in this hospital, I believe that the industrial workers can be of help to the patient struggling to get his health back. But the point of view of the industrial employee must be "How much value is this work in helping the patient recover?"

Sad to say, however, not all employees are trained to take that point of view. Every mental hospital should, I think, have a qualified supervisor with psychiatric training and experience to supervise all industrial departments where patients work and advise the heads of these departments and their workers on how to take care of the patients assigned to them. At our hospital a doctor has just been assigned to take care of the working patients and we are all delighted. Now, when we are puzzled, we ask the doctor what to do.

I cannot believe that occupational therapy, including arts and crafts, is the whole answer to keeping the patient busy in his leisure time. Many times I have had patients say to me "Do they think I am a kid? I did that kind of stuff when I was in school. Now I could do a day's work."

The main purpose of industrial therapy should be, as I have said, to help the patients get their health back so that when they go home they can do a day's work with other people. But another consideration is the saving of money in a tax-supported hospital. If all the patients were taken out of hospital industries, the first thing we would have to do would be to ask the Legislature for many more dollars a year to replace the patient workers with paid employees. It would be interesting to know just how much working patients in all the state mental hospitals save the tax-payers.

But we should think first of saving the tax-payer rather than his dollars, for if the doctor can return these patients to industry, it should be more important than dollars.

The patient who works every day in the hospital, as long as his health permits it, should have a better chance of getting a job when he is discharged than the one who simply sits around or does nothing but play games.

I try to use the ordinary commercial laundry methods so that my patients can get a job in an outside laundry if they wish.

Unfortunately, not all patients are placed in hospital industry solely because of their own needs. Often there is not enough paid help, so patients get assigned to a department anyhow, because help is needed. One difficulty which comes up then is—can we get the same production from the machines operated by patients as we can get when they are operated by paid help?

In our laundry I think we do. Many state hospitals don't use men patients in their laundries, on their ironers, but we have always had splendid results with men. And the men tell me that they think it helps keep them in condition to go back to work when they are discharged. Many of them have been textile mill workers before coming to the hospital.

I think that all industrial workers in state hospitals for mental illness could, with proper training from the doctors, be a great help in building up and restoring the patients to useful lives.

Patients' "Clothing Store" Established by Volunteers

No money changes hands in this unique store which was established in a heated garage on the grounds of N. J. State Hospital. Volunteer Aides collect clean, appropriate clothing in good condition from their friends and neighbors and everything is pressed and mended before it is hung on the rack. Shoes, handbags, underwear, shirts and sweaters are displayed on shelves.

The patients come to the store with Volunteer Aides and make their own selections. They are free to try on whatever they like and if the type of garment they want is not there the Volunteer Aides try to supply it within a week or so.

Patient Care Means Patient Comfort

By FREDERICK L. McDANIEL, M.D.
A.P.A. Central Inspection Board

All too often, in visiting and inspecting hospitals, I see many things neglected which could so easily be done for the comfort of the patient, be he acute or chronic, subject to a "total push" program or a permanent resident with little hope of recovery. Overcrowding and insufficient hospital personnel are largely responsible for these lacks, of course. In the effort to attend to the basic needs and also to administer a multiplicity of therapeutic procedures, other essential needs are often neglected. I feel very deeply about these things, because a little attention to them can make so much difference to the comfort and happiness of the patient.

In most hospitals, for instance, a patient is given a bath only twice a week unless he is "untidy" or is a bed patient, and very few patients are allowed to bathe themselves. Yet many were accustomed to bathing in their own homes and would be quite capable of doing the same thing in the hospital. The very act of bathing a patient with a large group of other patients is a regimented procedure, and there is usually little or no attempt at privacy. This situation is aggravated when a long line of human beings must stand in line naked to be bathed at a central bathing station. Most women, too, dislike shower baths, but are forced, in many hospitals, to stand in a shower for bathing. These routine procedures may be good organization from the point of view of ward personnel, eager to save time and effort, but are they good for the patients' own feelings?

Good Grooming Aids Morale

It is a normal procedure for a man to shave himself—and it is stimulating to our ego to be always well shaved. Yet in a great many hospitals, the men are shaved only twice a week. Others have discovered that many ambulatory patients can shave themselves with the locked type of safety razor. Hospitals which have a well-kept, professional barber shop with adequate facilities for the proper care of all patients are the exception rather than the rule, and few hospitals have enough professional barbers to meet the needs of all the patients if none of them are allowed to shave themselves.

A good word must be said for the hospital beauty parlors. Most of these are attractive and well-equipped and can accomplish miracles for the feminine sense of well-being. The women love them, but there is a deplorable lack of professional beauticians to cope with the needs.

Dental Hygiene Important

All hospitals of course provide patients with tooth brushes and powder, but not many have a dental hygiene program for the wards. And it is a rare hospital which has a full-time dental hygienist. There are usually only enough dental personnel to carry out routine examinations and to perform the most necessary dental work. In view of the increasing number of geriatric patients, invariably in need of dental prostheses, hospitals need a dental laboratory with a dental mechanic in charge. The present method of having dentures made in commercial laboratories is not entirely satisfactory. Hence the dietitian still provides the detested soft diet and ground meat for elderly patients.

A depressing sight is a geriatric ward, where so many old men or old ladies are sitting in chairs with folded hands, gazing into space. It would probably be found that many of them could, if provided with eye glasses, be able to enjoy reading the daily newspaper or the magazines. The usual objection is "They may break the glasses or injure themselves." Yet in many cases, the patient had his own glasses which he brought to the hospital with him, and which may have been stored away with his valuables.

Most people prefer to go to the toilet privately—yet in too many wards they must first go to the attendant and procure an issue of toilet paper. When they finally reach the toilet rooms, there are little or no provisions for privacy.

We are all familiar with the "hospital look"—the drawn cheeks, the dry lips, the dingy complexion. A low fluid intake and the resulting dehydration may well be the cause. All living things in order to survive and stay healthy must have an adequate intake of fluid to maintain a bodily water balance. Yet many mental hospitals do not have adequate facilities in the wards to supply drinking water for patients. In many cafeterias and dining rooms, although a patient may have coffee or milk, it is rare to see a glass of cold water at his plate. Moreover, some patients are not able to provide themselves with sufficient water, and the busy, overworked ward personnel sometimes fail to supply them with water as often as necessary.

The care of the feet is most important to the comfort and welfare of patients, especially the elderly. Although nearly all hospitals have a part-time podiatrist on the staff, part-time is not always enough to care for the needs of all the patients.

Rest Facilities Needed

There are often inadequate seating and resting facilities for patients' daytime use. This is especially true in the geriatric wards. Aged patients, especially old ladies, need short rest periods during the day. Some hospitals will not permit the use of night sleeping accommodations during the day unless the patient feels ill. Consequently patients must sit for hours on hard, uncushioned, straight-backed chairs.

Geriatric patients especially should have access to beds during the day for rest periods. It would be well if dayrooms could be equipped with enough couches for this purpose. This might "spoil the look of the ward", but it should be remembered that a "properly arranged," prim and tidy ward is not always a comfortable ward for the patients who must live in it.

I wish it could be recognized that the staff of a modern mental hospital have *two* primary functions. Certainly they must provide modern medical treatment; but they should also give attention to the comfort of patients by taking care of the small details which are so important in the life of every human being.

PROFESSIONAL CONFERENCES

New Drugs Discussed

Psychiatric clinicians from state, university, federal and veterans hospitals, as well as psychiatrists in private practice, spent two full days on a conference on Reserpine in the Treatment of Neuropsychiatric, Neurological and Related Clinical Problems early in February. The conference was held under the auspices of the New York Academy of Sciences, Section of Biology.

Although the conference was primarily concerned with Reserpine, the use of Chlorpromazine was also discussed in the treatment of psychoses.

Papers included accounts of studies in ambulatory and hospitalized geriatric psychotics, the treatment of chronic schizophrenic reactions, the use of Reserpine in shock-reversible and shock-resistant patients, the control of deviant behavior in chronically disturbed psychotics, the clinical evaluation of Reserpine in a state hospital on major types of mental disorders, the acute effect of this drug on central sympathetic reactivity, a comparison of the clinical use of Reserpine and Chlorpromazine, effects of the two drugs in the treatment of psychoses, and various studies of their use in private psychiatric practice and as an adjunct in the therapy of neurological disorders.

A recent study of Reserpine carried out at Rockland State Hospital, Orangeburg, N. Y., by Drs. Joseph A. Barsa and Nathan S. Kline on chronic disturbed psychotics has been accepted for publication in the American Journal of Psychiatry. At this meeting, Dr. Kline and Dr. A. M. Stanley, also of Rockland State Hospital, discussed the use of Reserpine on different types of services.

Other hospitals at which studies were reported included the VA Hospital, Iowa City, with the Psychopathic Hospital, Iowa; the VA Hospital, Palo Alto, Calif.; Manteno State Hospital, Illinois; Central State Hospital, Petersburg, Va.; East Louisiana State Hospital, Jackson, La.; St. Elizabeths Hospital, Washington, D. C.; the University of Oklahoma School of Medicine and University Hospitals, with the Oklahoma Medical Research Foundation; Baylor University College of Medicine, Houston, Texas, and a number of other medical research and teaching centers.

It was admitted that studies had not been of sufficient duration to justify any firm scientific conclusions, and the need for further investigative efforts was emphasized. There seemed to be a consensus that these drugs, although still in the earlier phases of study, might well be expected to become valuable adjuncts in psychiatric therapy, particularly in the treatment of the chronically disturbed patient.

Ex-mental Patients' Needs Subject of VAVS Meeting

The general fostering of public understanding and the dispelling of public fear of the discharged mental patient were stated to be the most important factors in the community rehabilitation of psychiatric patients. These conclusions were reached by representatives from the forty-one organizations represented at the annual meeting of the Veterans Administration Voluntary Service (VAVS) National Advisory Committee in Washington early in February.

At the three-day meeting one complete day was devoted to discussions on "Community Action in the Rehabilitation of the Mentally Ill." The topic was key-noted by Admiral Joel T. Boone, Chief Medical Director, and Dr. Harvey J. Tompkins, Chief, Psychiatry and Neurology of the Veterans Administration.

Five workshops discussed how the members of the VAVS participating organizations could help in the job, and each of the five arrived independently at some common conclusions.

Practical suggestions included working through the local mental hygiene societies, and the utilization of mass media such as televison, radio, local newspapers and magazines. P.T.A. meetings and other civic and community groups should also be approached to help further public knowledge of the problem of the "mentally handicapped" who on leaving the hospital need jobs, social life and community acceptance in order to again become full members of their families and communities.

Volunteers could do much on an individual basis as well as through their organizations, but even so, individual activities needed direction and orientation. For instance, volunteers who had been carefully oriented could do much to amelioriate the problem of the patient who is withdrawn from the hospital by his family against medical advice, to reassure the family about his treatment and its purposes, and to act as a liaison between family and patient should the veteran's hospital be too far away for regular visits to be paid. During the pre-discharge period, volunteers could do a great deal to educate the patient himself about the problems he is likely to meet after his discharge.

Because volunteers themselves quickly lose any fear they might have had by working closely with mental patients, they can do more than almost anybody to reassure other people, including the patient's own family, that he is "safe". It should be realized however, that returning a psychiatric patient to his community is a complex job and needs effort and thought on the part of the hospital, the family, the patient himself and the volunteer, who can be the "bridge" between the various groups and individuals involved.

Two specific recommendations were that all VAVS organizations should put on an all-out publicity drive especially during Mental Health Week in May upon the community's responsibility toward the discharged patient, and also that the program of planning for patient discharge now being carried out in 13 Veterans Administration hospitals should be encouraged and extended to hospitals which do not yet have such a program, as it would be of special value to the psychiatric patient.

It was emphasized that while these groups were discussing specifically the problems of the psychiatric patient discharged from a Veterans Administration hospital, the problems and their solution were almost equally applicable to any tax-supported mental hospital.

M. H. S. News & Notes

Program Planning Underway for 7th Mental Hospital Institute

A meeting of the Program Committee for the Seventh Mental Hospital Institute was held in Washington on February 16 to consider program suggestions which had been submitted by participants in previous Institutes. Consensus was that the theme of the next Institute should focus on changing concepts of the mental hospital, and should encompass such subjects as the growth of "open hospitals" and increased patient participation in their operation, the challenge of providing adequate specialized facilities for emotionally disturbed children, the increasing belief that the mental hospital can no longer be considered the only effective setting for dealing with the mentally ill, and related topics.

The general structure of this year's Institute, to be held October 3-6 at the Sheraton Park Hotel in Washington, D. C., will follow that of previous years. It will consist mainly of plenary sessions, with emphasis upon discussion from the floor. Two hours will be devoted to simultaneous sessions for special interest groups on such topics as dietetics and mental deficiency.

The Program Committee consists of Dr. Harvey J. Tompkins, Chairman, Dr. Granville L. Jones, Dr. Gale H. Walker, and Mr. R. Bruce Dunlap, and is assisted by Dr. Daniel Blain and other professional and executive staff of the American Psychiatric Association. It will meet again within the next few months to formulate final program plans. A theme for the program will be announced at a later date.

New Booking Forms to be Sent for M.H.S. Film Library

New booking forms on which films from the M.H.S. Film Library may be ordered will soon be sent to all full-service ($50) subscribers to Mental Hospital Service. The new booking forms will list two new titles which are being added to the Library, bringing the total number of films listed to eleven. Details of the new films will be announced in the April issue of MENTAL HOSPITALS.

A limited number of the old booking forms are still available. Any full-service subscribers, including the 25 institutions which have joined M.H.S. during the past two months, which need film order forms before April may request them from Mental Hospital Service.

List Available of Schools Offering Hospital Administration Programs

A list of schools offering programs in hospital administration is available on request from Mental Hospital Service.

This list was prepared by the Information Service of the A.P.A., and in addition to university programs it includes programs unaffiliated with the Association of University Programs in Hospital Administration.

Last Call for Achievement Awards

The closing date for entries in the 1955 M.H.S. Achievement Award competition is March 15. Projects which were submitted in previous years' competitions but did not receive an Award may be brought up to date and re-entered this year. Four copies of the application are required.

NATION TACKLES MENTAL HEALTH PROBLEMS

This year promises to be one of unprecedented activity of great significance to mental health and mental illness, both in Congress and in State legislatures. Over 50 bills, both Federal and State, reflect nationwide determination to tackle these problems on a scale suitable to their magnitude.

President Eisenhower keynoted the growing national concern, in general terms in his State of the Union Message on January 6th, and more specifically in his Health Message on January 31st.

The following presentation – the President's and the State Governors' own words, each followed by brief resumés of Bills pending – is given to enable hospital people to keep in touch with developments which so intimately concern them and the patients they care for.

MENTAL HOSPITALS will endeavor to keep its readers in touch with developments as they occur by reporting upon new state legislation as it is passed, and upon hearings in Washington as they take place. No attempt is made to evaluate the merits of any of the Bills. They are noted as an indication of trends throughout the country.

The President Speaks

"To reduce the gaps in medical services, I shall propose—

Vigorous steps to combat the misery and national loss involved in mental illness;"

State of the Union Message, January 6, 1955

"Care for the mentally ill presents a special set of problems.

"Only in the past few decades have we, as a people, begun to regard mental and emotional disorders as capable of specific diagnosis, alleviation, cure and rehabilitation. We now know that effective preventive and control programs are possible in the field of mental health.

"I recommend, therefore, new and intensified measures in our attack on mental illness. These are:

"1. Strengthening of present aid to State and community programs for the early detection, control and alleviation of mental and emotional derangements;

"2. Increased budgetary support for training activities which are now authorized, so as to increase the number of qualified personnel available for care of mental patients; and

"3. Authorization of a new program of mental health project grants. Such projects would aim at improving the quality of care in mental institutions and the administration of the institutions themselves. They would also search out ways of reducing the length of stay and the necessity for institutional care in as many cases as possible."

Recommendations Relative to a Health Program January 31, 1955

Congress Acts

Hill Bill Seeks to Create Professional Commission

Among Federal proposals of special interest is Joint Resolution No. 46, introduced by Senator Lister Hill of Alabama, which reflects discussions by the American Medical Association Council on Mental Health, the American Psychiatric Association and other professional groups last fall and winter. This bill seeks to establish a joint, non-governmental commission to help solve the complex problems posed by mental illness by encouraging a non-governmental, multi-disciplinary research into all its aspects. For this purpose, an initial appropriation of $250,000 is asked for the fiscal year ending June 1956, to initiate such a research and study, and $500,000 for each of two succeeding fiscal years to make such grants as may be needed for its continuation. Such appropriations would not affect any other money appropriated for work in mental health or mental illness research, and any of the agencies involved would be free to seek or accept additional financial support from private or public sources.

The possibility of such a joint commission, resulting in a report after the style of the "Flexner Report" on Medical Education has been discussed extensively by top ranking professional agencies during the past few months. (See MENTAL HOSPITALS, December 1954, "Massive Support, Adequate Budgets Needed for Psychiatry to Fulfill Obligations" and MENTAL HOSPITALS, February 1955, "Joint Commission Proposed to Formulate Future Needs.")

In a statement addressed to the President, which accompanied the introduction of the bill, to be known as "The Mental Health Study Act of 1955" Senator Hill said:

"(These agencies) have decided that our best hope to find a solution to this staggering problems lies in a thoroughgoing, nation-wide analysis and re-evaluation of our entire approach to the problems of . . . mental health. . . . I agree with the organizations mentioned that such a review and re-evaluation of the problem can best be conducted by such non-governmental agencies and organizations as those co-operating with the A.M.A.'s Council on Mental Health and the A.P.A. I believe it is the responsibility of the Federal Government to offer financial assistance in the conduct of such non-governmentally directed undertaking.

"The bill I have today introduced would carry out this desirable concept by making available over a three-year period a substantial grant to be made upon recommendation of the National Advisory Mental Health Council to qualified non-governmental agencies, organizations or commissions composed of representatives of leading national medical and other professional associations for the kind of survey and re-evaluation needed. The sums which would be authorized in the bill are designed to supplement and not replace similar funds which it is hoped will be made available from private sources. Hearings on the bill will, I believe, bring out an accurate estimate of the total cost which will be involved in such an undertaking."

Grants-in-Aid Asked for Research Facilities

Another bill introduced by Senator Hill, with Senator Styles Bridges of New Hampshire, is called "The Medical Research Act of 1955." This attempts to provide for grants-in-aid to accredited and non-profit universities, schools of medicine, hospitals, etc., to construct facilities or install equipment for research into the causes of and possible cures for crippling and killing diseases, including cancer,

heart disease, poliomyelitis, nervous disorders, mental illness and so on. For these purposes a total appropriation of $30,000,000 is requested for the next three fiscal years.

The bill would also create in the Public Health Service a National Council on Medical Research Facilities, under the chairmanship of the Surgeon General, with representatives from each of the national advisory councils attached to the National Institutes of Health, to act upon applications for such grants-in-aid.

Experimental Projects to Receive Special Grants

Yet a third bill also introduced on February 1st by Senator William A. Purtell of Connecticut, would make certain amendments to the National Mental Health Act, notably for providing grants to States to pay part of the cost of public health services in the field of mental health, and to make possible demonstrations and experimental projects for improving operation of mental hospitals, treatment and rehabilitation of patients in these hospitals, reducing hospital time and improving physical facilities especially for ambulatory patients.

All three bills have been referred to the Committee on Labor and Public Welfare.

The Governors Speak

The area of state government which affords me more justifiable pride and genuine satisfaction is the field of mental health.

"Upon my recommendation the last General Assembly created a separate Department of Mental Health, and for the first time in history a concentrated effort has been made to improve the unenviable plight of the living dead of our State mental institutions. . . .

"For the first time in history our correctional institutions have been separated from our mental institutions, and our mentally ill citizens are in the sympathetic custody of a trained and qualified psychiatrist and are now being treated and restored to civilian life at a rapidly accelerated pace. . . .

"By rearranging space, we have provided 161 additional beds without any significant cost to the state.

"Our funds have been limited and unfortunately must continue to be less than the desired level; however, we are now spending at the rate of $1.60 per patient per day as against $1.14 in June of 1953. Fairness compels me to admit that the national average is $2.56, so despite our manifest progress we are continuing to spend much less than our neighbors in this humane field of endeavor.

"Our existing physical facilities are not what we would like, but budgetary limitations forbid any substantial new construction or expansion program at this time. Our major problem continues to be the procurement of trained personnel, but vast progress is being made along this line.

"I shall submit for your consideration certain legislation designed to simplify admissions to our various mental institutions. These proposals will be remedial, corrective and procedural in nature. I ask your careful consideration of each of them and recommend that they be enacted into law.

"I shall likewise recommend an appropriation of $4,100,000 for the biennium with which we shall strive to maintain and improve our mental health program in accordance with the accepted standards of the progressive and enlightened era in which we live."

Governor Frank G. Clement, Tennessee

"At the present time our state mental hospitals are 22 per cent overcrowded. It is estimated that in another ten years mental cases will increase another 25 per cent.

"The only way to avoid a gigantic building program in the years to come is to reduce the populations through concentrated treatment and prevention. That is the emphasis of our requests at this time. . . .

"There is a definite correlation between degree of personal attention and cure. For this reason it is necessary that we add new employees to our state hospitals and schools for the mentally deficient. . . . We need research personnel, psychiatrists, nurses and attendants.

"A program that I propose which would help reduce the number of mental cases at the doors of our hospitals and speed the release of those admitted is the establishment of three mental health clinics. Here people also could come voluntarily, before hospital treatment is necessary, thereby reducing the hospital population. Many patients could be released earlier from mental hospitals because they would have a place to go for periodic checkups. The establishment of these clinics also would be a step in the direction of bringing our training program for student psychiatrists up to standard, thus attracting new professional people to carry on the program through the years.

"In the field of our mentally deficient children, the population pressures are most severe. There are 573 court-committed cases now on the active waiting list of our two schools. Forty-two per cent of these are non-walking, completely dependent children. It is estimated that 134 children will be added to the list each year.

"A third institution for the mentally deficient cannot be avoided. When the present building programs at the two institutions are completed, it is felt that no further expansion at those locations is desirable. I am proposing that an enabling act be passed to establish this new institution which would be planned for about 1,500 children."

Governor Arthur B. Langlie, Washington

"At the request of a recent Southern Governors' Conference, there was conducted an audit of mental health and training research in West Virginia. This audit will provide basic information on which programs, particularly in the field of mental health, can be determined."

Governor William C. Marland, West Virginia

"In recent years we have become increasingly aware of the fact that mental illness among our people, while serious, is not hopeless. Gradually through education and actual experience the public is losing many of its former prejudicial and superstitious attitudes and is becoming interested in learning more about the causes of mental and emotional illnesses and mental handicaps.

"California has devoted a generous share of its resources toward the care and treatment of the mentally ill and the mentally handicapped and will continue to take advantage of new and accepted treatments and techniques, so that the mentally ill and mentally

handicapped will return to their homes at the earliest possible time. However, we know that mere application of the knowledge we have already attained is not sufficient. Building new buildings—as necessary as they may be—cannot be accepted as the final answer. We must intensify our research, education and training programs. In order to fight this ever-increasing danger successfully we must learn more about the cases of the illnesses and handicaps and how to prevent their occurrence."

Governor Goodwin J. Knight, California

"We will act in the fields of social progress, the things of humane concern such as public health, the care of retarded children and the mentally ill, the advancement of public education, the prevention of discrimination among our people."

Governor George M. Leader, Pennsylvania

"Our progress in the care of the mentally ill has been dramatic. We must continue this program. I have provided for its continuation in the budget.

"Since the beginning of our expanded mental health program we have also made great progress in the physical condition of these institutions. . . .

". . . We are all proud of this program. Our faith in it is dramatically revealed by the monies expended on the mental institutions during the past four years. In 1949 we expended a total of $3,583,000 for the operation of this program. This year, 1955, we are spending approximately $10,800,000 for operating expenses. I have recommended approximately $11,300,000 for 1956. These figures do not include the expenditures for capital improvements which have also increased. . . ."

Governor Fred Hall, Kansas

"While there are specific programs and efforts to deal separately with some of these social problems (mental health), as in alcoholism, it is clear that a statewide preventive program to conserve and promote mental health, as distinct from the diagnosis and treatment of mental disease, will affect favorably many of the social problems which now confront us all."

Governor Robert B. Meyner, New Jersey

The Legislators' Act

Over 50 House and Senate bills in 21 states relate to different phases of mental health and mental illness, their purposes ranging from establishment of facilities for child psychiatry and mental deficiency to the establishment of entirely new mental health authorities. The following presentation outlines briefly some of the most far-reaching bills.

Arizona is considering an emergency bill for the establishment of a statewide preventive mental health program. Two Senate bills in California seek to extend the jurisdiction of the Department of Mental Hygiene to organize, establish and maintain community mental health clinics, clarify the laws relating to sexual psychopaths, licensing of private mental institutions, release of a patient on parole and various other matters. Several Assembly bills deal with similar matters.

Connecticut has an Assembly bill pending to obtain an appropriation for financial assistance for training in child psychiatry; another bill attempts to provide examination, diagnosis and treatment for offenders against the law who, although not legally mentally ill, have certain psychiatric disorders which necessitate commitment for a time. Two other commitment bills have also been presented.

Georgia wishes to amend an act establishing juvenile courts so that children believed to be physically or mentally ill or defective may be examined, and if necessary, treated in appropriate facilities.

Separate Division Asked

A series of House bills introduced at the regular session in Indiana spell out far-reaching organizational reforms directly relating to mental health problems. A separate division of mental health is requested within the Department of Health and the qualifications and responsibilities of the Commissioner for Mental Health are specifically stated. Definitions are the sole subject of two more bills, and an Act is introduced concerning the transfer of inmates of any penal or correctional institution to a psychiatric hospital; in this bill the procedure is fully described. One emergency bill concerns commitments to Beatty Memorial Hospital.

Mental Health Authority Established

In Iowa a mental health authority is to be established, this authority to be vested in the psychopathic hospital in Iowa City, and a mental health committee is to be formed; two more bills request establishment of psychiatric departments in certain county hospitals and a facility or facilities for the care, diagnosis, treatment and training of emotionally disturbed and mentally retarded children. Confinement of persons who are considered dangerous criminal sexual psychopaths is also requested.

In Missouri a Senate bill specifies commitment and discharge procedures, care of hospitalized mental patients, and confidentiality and maintenance of medical records. Another bill seeks to establish a state mental health commission consisting of three members, to be appointed by the Governor, all of whom shall be physicians and at least two "skilled in the practice of psychiatry and one in the practice of neurology." This commission is to advise the director of the division of mental diseases on all phases of patient care, training, treatment and other relevant matters. A third bill seeks to establish traveling psychiatric clinics.

Commitment Clarified

A Massachusetts House bill attempts to reform and clarify commitment procedures. One Nebraska bill revises statutes relating to the commitment of sex deviates, providing for voluntary admission to state hospitals in some cases. A second bill seeks to provide an advisory board for each mental health facility in the state, and another to establish a division of vocational rehabilitation for the "physically and mentally impaired."

Two Senate bills introduced in New Mexico were referred to the Judiciary Committee. One related to delinquent minors and seeks to have the state hospital at Las Vegas provide suitable facilities for care and treatment, and the other relates to the in-

sanity of defendants in criminal cases.

New York state Assembly and Senate bills seek to amend the mental hygiene law in relation to the care and treatment of those who might be "dangerous to the people of this state." Another bill seeks to establish a separate institute for the treatment of senile psychoses, while two Assembly bills deal with legal assistance in commitment proceedings. A North Carolina House bill definies a sexual psychopath as a person, not insane, who has been guilty of repeated misconduct in sexual matters giving evidence of lack of power to control these impulses. The bill provides for psychiatric examination of such persons.

Voluntary Admission Allowed

A North Dakota bill amends the Code on the admission, custody and release of state hospital patients, and provides for voluntary admissions. Alcoholics and drug addicts are included by the provisions of the bill. South Dakota wishes to empower its state mental health administrator to establish and supervise mental health clinics, and to inspect annually or as often as may be necessary both private and public mental hospitals and wards or parts of hospitals having care of psychiatric patients.

In Tennessee a House bill proposes voluntary admissions to state and private mental hospitals.

Emergency Bills in Texas

Four Texas House bills, declaring an emergency, were each referred to the Committee on State Hospitals and Special Schools. The bill dealt with the return of patients released from state hospitals or schools, providing for their care if necessary. Another bill, referred to the Committee on Constitutional Amendments, proposed an amendment that the Legislature may provide for "trials of lunacy cases without a jury." Another was referred to the Committee on Civil Jurisprudence, and proposes to revise and arrange certain statutes relating to juvenile delinquents. This bill, too, declares an emergency.

Another bill concerned with insane persons in conflict with the law is pending in Utah, which would provide commitment to the state hospital if a defendant is found insane. The state of Washington seeks to provide a procedure for determining legal insanity and providing for commitment; should the defendant be received into the state hospital he must be detained there until he becomes sane, when he may be brought to trial or judgment, or legally discharged by the dismissal of the charge against him. This State also seeks to provide psychiatric outpatient clinics in state hospitals, as well as local or community mental health committees and a mental health program, and better care for the mentally deficient.

Habeas Corpus Provided

A West Virginia House bill redefines the terms used in Articles of the Code relating to mentally ill persons and directs in what way the mentally ill should be committed and taken to hospitals. The bill also provides for emergency procedures, and states that any individual shall be entitled to a writ of habeas corpus upon proper petition by himself or a friend. The commitment of inebriates and the criminally mentally ill is provided for, and provisions are outlined for the release, discharge and readmission of patients of all categories.

This bill also provides that the Board of Control must give a permit to enable a private mental hospital to operate, and details those eligible for training in the state school, together with commitment procedures. Payment for maintenance of any publicly cared for patient is discussed and boarding home care is defined and regulated.

Wyoming is considering a bill on the commitment of insane or feebleminded persons either to Wyoming State Hospital at Evanston, or if eligible, to the VA Hospital at Sheridan. The commitment procedure is detailed. If the person is not "dangerously insane, nor mentally defective, but by reason of old age, disease, weakness of mind, feebleness of mind, or from any other cause incapable unassisted to properly manage and take care of himself or his property," the court may order him to be placed in the custody of a friend or relative who will assume his custody and care and maintenance without expense to the state or county.

ARCHITECTURAL STUDY

Study Project to Become Self-Supporting

Since its establishment in 1953 under grants from Rockefeller Foundation and Division Fund of Chicago, the Architectural Study Project has gathered considerable data regarding mental hospitals, both public and private, day hospitals, intensive treatment centers and outpatient clinics.

Much help has been given to state officials and members of the American Psychiatric Association in helping them to plan modern, functional buildings. Up till this time, such help has been given free.

To sustain a continued study, however, when the two year period is up, it will be necessary in future to make a modest charge for consultation by members of the Architectural Study Project staff whenever there is construction involving a contract. This service will be available to both individuals and to governmental agencies, and the consultation will be charged for whether the request comes from a member of the American Psychiatric Association or the American Institute of Architects.

Consultation costs will, of course, vary according to the amount of work required, how much time and investigation is involved and how many members of the staff are needed.

During the study period, the staff has advised effectively on complete master programs for entirely new mental hospitals, including the requirements of different facilities for different classifications of patients; the basic elements of a new or existing admission and receiving service—diagnostic and treatment areas, inpatient and outpatient areas, occupational and recreational facilities, service areas and so on; and whatever details of equipment and materials were needed.

Problems in Planning a Small Receiving Building

Richard Koch, A. I. A.
New Orleans, Louisiana

G. W. Davis, Jr., M.D., Clinical Director
Southeast Louisiana Hospital, Mandeville

When we began preliminary discussion of plans for a receiving building for Southeast Louisiana Hospital, there were several limits beyond our control and several needs—some of which could not be predicted accurately.

The first limit was the amount of money available for construction of the building. Related to this was the number of beds to be provided. We also had to plan for four services, male and female, white and colored. Our limits, therefore, dictated that we plan a 100-bed building containing four services.

Our needs were more complex and less easy to define. In the Intensive Treatment Unit, the only patient building in operation, we had difficulty separating patients according to classification, because of architectural limitations. Therefore we wanted to divide each of the four units into as many sub-units as possible.

Need for Flexibility

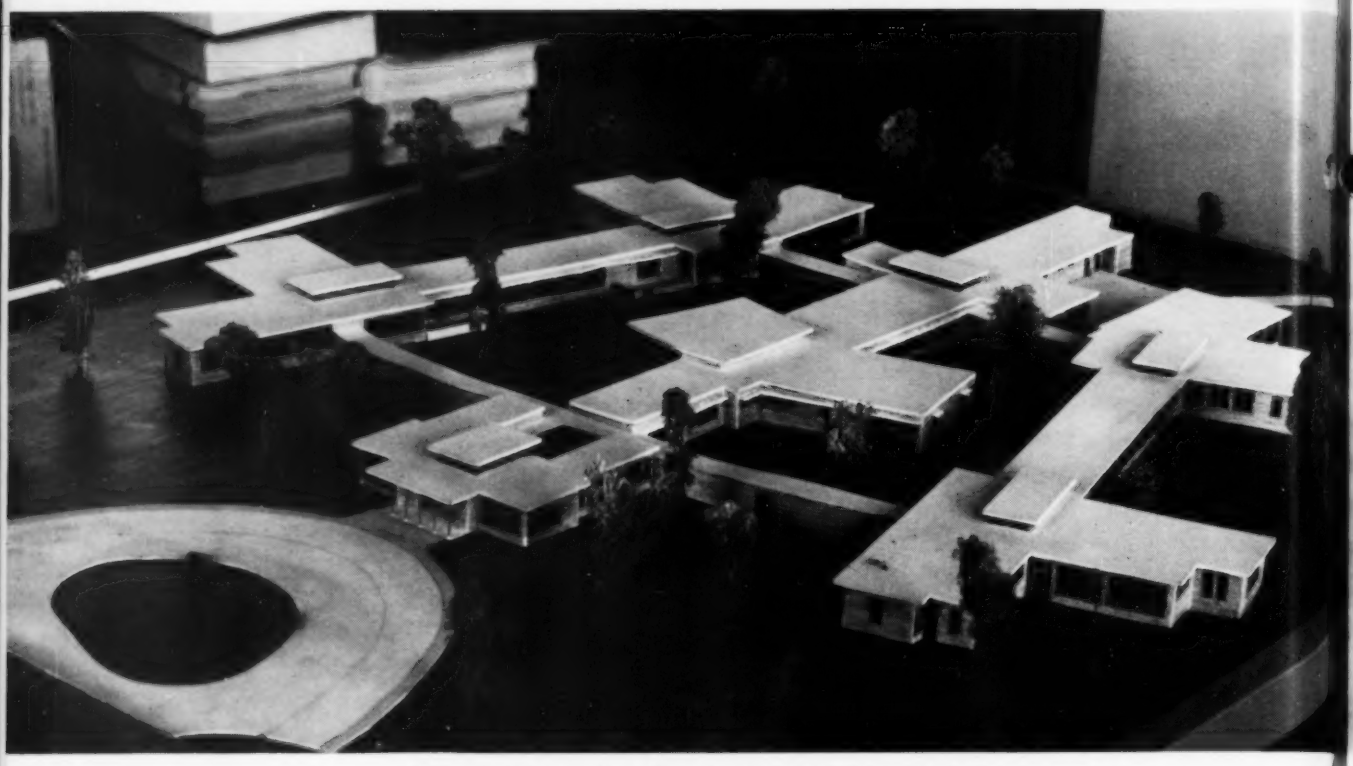
We wanted to be able to adjust the sizes of the units and sub-units to fit changing needs. The admissions to the different services of the Intensive Treatment Unit have been out of proportion to admissions to state hospitals having all services—geriatric, continued treatment, etc.—which we will have eventually. The white female admissions have been relatively greater than we ultimately expect. Hence, we needed to plan a building that could be used for the present admission rates and to anticipate long term changes in the admission rates to the four services.

In talking with various people throughout the country about this problem we found that many psychiatrists strongly advocated the use of temporary partitions that could be moved as needed. However, we never talked to an architect who agreed with this theory, all of them preferring to "build the flexibility into the building."

We also wanted to make treatment, O. T., recreation, food service, linen service, etc. available to and near all services.

We wanted to supply adequate office space for professional personnel and others, located in such a way that it would be close to the wards and the treatment area, yet so placed that patients being admitted and their families could be interviewed, patients' visitors seen, and outpatients treated without interfering with the activities and treatment schedules of the inpatients.

We were able to satisfy most of our



Photograph Shows Model of New Small Receiving Building,
Southeast Louisiana State Hospital

needs by the rather traditional arrangement of a central group of buildings, having from front to back: admission and visiting areas and offices; treatment, recreation and O. T.; dining rooms; kitchen and linen room. The ward buildings on either side are connected to this central group by walkways which have one wall and a roof. The inner or courtyard wall was omitted since protection from sun and rain is needed, but rarely protection from cold.

Wasted Areas Eliminated

In the existing building we have been quite conscious of the wasted courtyards and patios—beautiful spaces which have not been used as planned. In this building we have tried to make these spaces an integral part of the building by omitting the wall between the courtyard and the inter-building corridors as noted above, and by omitting the "inner" wall in the area of the front offices, so that a person leaving a physician's office is not confronted by a wall and a patio beyond, but by the patio just across a roofed passage.

To be able to have three sub-units in each service we planned three patient areas on three sides of a nursing station and lobby, 9 beds for depressed and disturbed patients, 8 beds for intermediate patients, and 8 beds for patients able to be responsible for themselves.

Conversion by Movable Doors

Our only departure from the usual is in the intermediate patient area. Here the bedrooms (2 bed dormitories) of one service are contiguous with those of another. The corridor is continuous. It is provided with three door jambs but only one door. By moving the door, one intermediate sub-unit may be changed from its usual 8 beds to 12 beds or to 4 beds while the adjoining intermediate area varies inversely.

If necessary the door can be removed completely, converting the two intermediate areas into one 16 bed unit which can be used as a part of either service.

In other words the four 25 bed services can be converted into two 33 bed and two 17 bed services; or one 33, one 17, one 29, and one 21 bed services, etc. as the need arises.

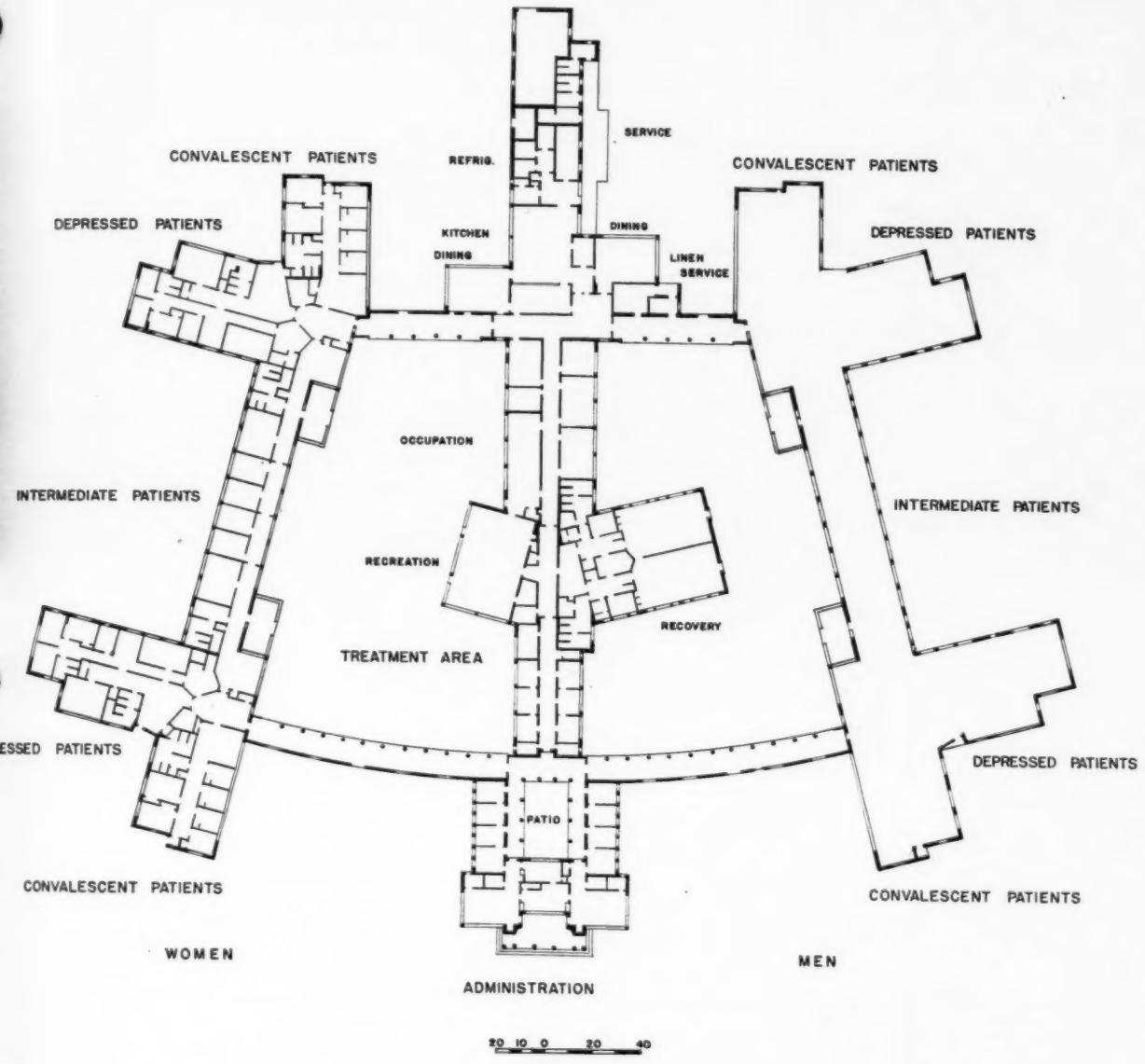
We believe that we have planned for as much flexibility by moving doors as could be gained by moving walls or erecting temporary partitions within a 100-bed building.

In the treatment area we have tried to plan our space so that it can be used for more than one purpose. We have also tried to route traffic advantageously. By providing doors to the courtyard we have made provision for E.C.T. patients, for example, to leave the recovery area without passing through the treatment area.

Multiple Traffic Flow

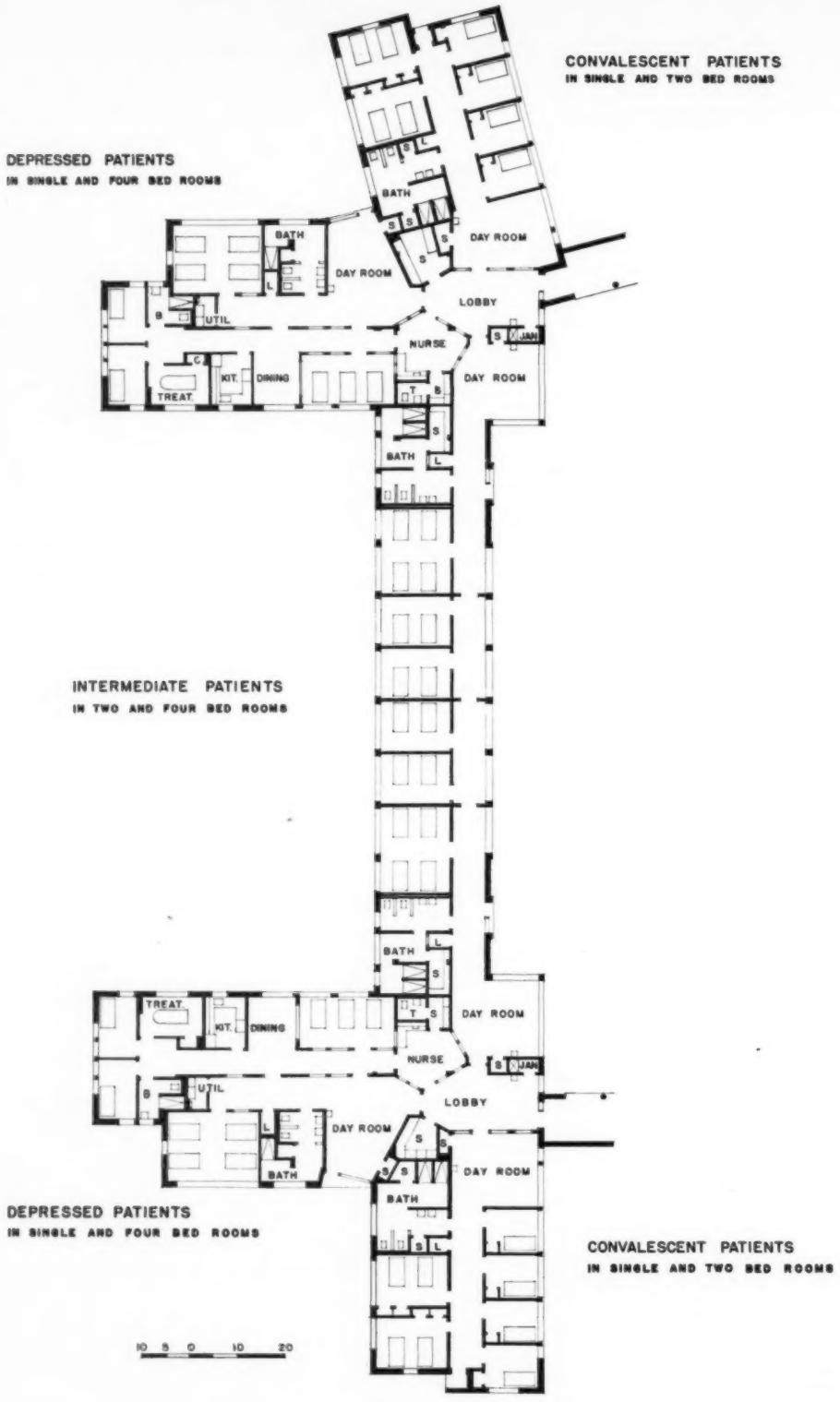
In the dining area we have planned 3 flows of traffic past one serving area so that two patient dining rooms and the staff dining room can all be served from the same cafeteria counter, thus saving the cost of two installations. Again this was done by arranging doors so that traffic could be directed in through one of two entrances and out through one of three exits.

In short, we have attempted to provide a small building with some of the advantages of a larger building by arranging space so that it will allow multiple uses or varied uses to satisfy both current and future needs.



KEY PLAN

(For details of nursing units, administration and medical facilities, see plans overleaf.)


CONVALESCENT PATIENTS
IN SINGLE AND TWO BED ROOMS
DEPRESSED PATIENTS
IN SINGLE AND FOUR BED ROOMS
BATH
DAY ROOM
LOBBY
NURSE
UTIL.
TREAT.
KIT.
DINING
INTERMEDIATE PATIENTS
IN TWO AND FOUR BED ROOMS
DEPRESSED PATIENTS
IN SINGLE AND FOUR BED ROOMS
CONVALESCENT PATIENTS
IN SINGLE AND TWO BED ROOMS
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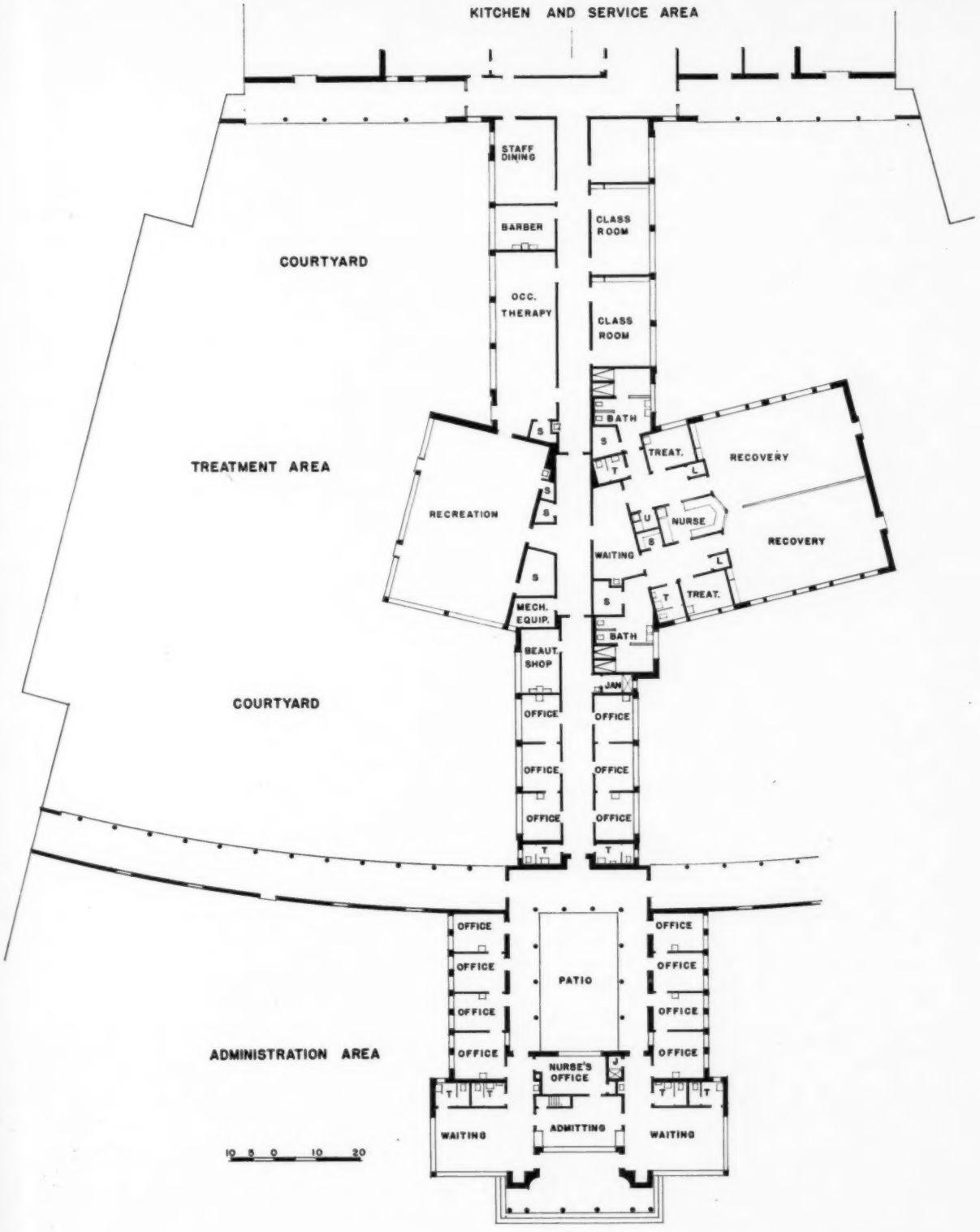
KITCHEN AND SERVICE AREA
STAFF DINING
BARBER
CLASS ROOM
COURTYARD
OCC. THERAPY
CLASS ROOM
BATH
TREATMENT AREA
TREAT.
RECOVERY
RECREATION
NURSE
RECOVERY
WAITING
TREAT.
MECH. EQUIP.
BATH
BEAUT. SHOP
JAN
COURTYARD
OFFICE
OFFICE
OFFICE
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NURSE'S OFFICE
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Goals of Psychiatric Planning

By PAUL HAUN, M.D.,
Assistant Professor of Psychiatry,
Bowman Gray School of Medicine, Winston-Salem, N. C.

At a recent meeting of the Board of Consultants to the Architectural Study Project, Dr. Paul Haun, formerly Chief of the Hospital Design Unit, Psychiatry and Neurology Division of the Veterans Administration, was invited to give an informal talk on programming for a new hospital building. The various points which he raised were enlarged upon during the group discussion which followed.

We are publishing the recorded notes from his talk because of their general interest to all who face construction problems.

Dr. Haun is the author of "Psychiatric Sections in General Hospitals."

The necessity of a medically appropriate location for the psychiatric hospital, the range of acceptable bed capacities, the need of auxiliary treatment buildings, and the desirability of avoiding a forbidding, asylum-type of architecture have all received wide publicity and, I hope, pretty general acceptance.

There has been less attention paid to other areas of the total problem of hospital design, and it seems worthwhile to try and make some of these explicit. Among many pleasant experiences while I was working with the Veterans Administration, one stands out in my memory as illustrative of the point I want to make. While the Army Corps of Engineers was acting as intermediary between the Veterans Administration and the private architectural firms charged with the responsibility of design, it became the practice for representatives of the architects to bring their Phase A drawings in to Washington for review. By this means I had an opportunity to meet a considerable number of architects and to get some idea of their methods.

For a long time I made a conscientious effort to explain what we as psychiatrists were trying to accomplish in the program; what happened in various buildings; and the needs of the patients and the staff. Either because I was unable to make myself clear or for other reasons, I was frequently disappointed by how poorly the medical requirements were met in the preliminary stages of design.

The Physician's Goals

I then took to making sketches in an effort to illustrate what I seemed unable to put into effective words and when this, too, failed of the desired results, turned to making overlays within the parti of the building as already determined by the architect. It was in this setting that a couple of architects who had designed a 250-bed general hospital with a psychiatric section arrived at Central Office with their preliminary drawings. I was disappointed in their plan and spent the better part of a day working on an overlay which I gave them the next time we met. They studied it closely, asked a number of pertinent questions as to the reasons for various arrangements in my plan, and then asked if I would object if they re-studied the problem that evening and submitted some alternative sketches the following day.

I of course agreed and the next day was shown what I still believe to be the best solution of that particular problem I have ever seen, vastly superior not only to my drawing, but also a great deal better than the one they had initially prepared.

I mention this because it seems to me to illustrate the nuclear importance of effective communication between architect and physician if medical needs are to be met in structural terms. I believe, however, that it is necessary to qualify this statement in two ways: first, the physician must be one who has clearly identified his own professional purposes; and second, the architect must not only have technical competence, but, in addition, the ability to set aside his own preconceptions and be possessed of a real desire to understand the physician's goals.

As a step in the direction of better communication between physician and architect, I have attempted to identify some of these professional purposes and to give them structural expression. I would like to offer them to you for correction.

(1) The building should be designed for the specific purpose it is to serve. Its size, bed capacity, height, architectural style and components will be determined only by its purposes; and its success measured in terms of how efficiently it meets its intended utilization.

(2) A building made to serve too many functions loses its effectiveness in algebraic progression as non-medical considerations force the addition of extraneous elements. Detroit could design toasting grills on our automobile exhaust piping, but it would not be an efficient way of preparing our breakfast toast.

(3) Site planning should insure functional relationships between buildings and services in the context of multiple operational and esthetic considerations. This is a significantly important area which, although of the greatest importance to the doctor, is all too often relegated by him to the architect and by the latter to his engineering staff. It does make a difference which building is placed next to which, where service entrances are located, how roads and sidewalks are laid out, what form the tunnel system assumes, where visitors' parking facilities are placed.

Needs of Each Department

(4) The building should be planned in terms of the specific convenience of each hospital service having dealings within it. The physician tends to focus on offices and patient accommodations since these are his primary concern. He must also interest himself in janitors, elevator operators, food handlers, maintenance men, garbage collectors, and all the rest, since awk-

ward. dangerous or inoperable provisions for any service or activity in the building will immediately impair the caliber of patient care and perhaps bring it to a standstill. These are not matters which can properly be turned over to the architect, because none can be expected to have the intimate familiarity with actual hospital operations ground in the bone of the mental hospital physician. The doctor needs to ask himself many questions as he looks at the drawings for a proposed building, such as: "What happens to the clean linen after the laundry truck drives up to the service entrance?" "If I were assigned as the janitor of this building, how would I organize my work?" "How do visitors to a patient in this room find this particular building, get into it, arrive on the proper floor, and pass through these locked doors?" "What has been done structurally to help the assigned occupational therapist use her time more effectively?" "What is going to happen when this water closet is stopped up with a bath towel?"

(5) The size of independent nursing units should be reduced to human proportions with the intent of making possible effective individual contact between staff member and patient.

(6) The integrity of the independent nursing unit should be structurally accented. Obligatory movement of patients through nursing units not their own should never occur, since effective classification of patients cannot otherwise be maintained, inadvertent psychic or physical trauma avoided or group spirit effectively developed. Common facilities regularly visited by patients from more than one nursing unit should always be centrally located for the same reasons.

(7) A conscious effort should be made in design, decoration and furnishings to give the nursing unit a congenial, relaxed, comfortable and cheerful atmosphere.

(8) Psychiatric safety and security needs should be carefully analyzed for each building and appropriate measures inconspicuously incorporated into the building design. The elimination of open stair wells; the chamfering of corners; the use of properly mounted, tempered glass of suitable thicknesses; careful choice of window sash; the employment of radiant heating; flush lighting fixtures, proper ceiling heights, concealed plumbing and many other features are all instances in point and are being employed to such good effect in certain new buildings that they can be identified as having security features only by the genuinely sophisticated observer.

(9) The building—and particularly the nursing unit—should be designed with studious attention to the comfort and convenience of the patient. The location of toilet facilities, of day rooms, clothing locker rooms, dining rooms, and recreational areas requires much thought and careful tailoring to the needs and activities of the specific patient group.

(10) The building—and particularly the nursing unit—should be designed with careful attention to the comfort and convenience of the staff. Highest priority should be given to those who spend the greatest amount of time in the area. Usually this will be the nursing staff. Locker, toilet, and lounge rooms for nurses and attendants merit particular mention since they are so often forgotten. The grouping of such facilities as linen storage closets, supply closets, and utility rooms in locations affording maximal convenience to the nursing staff is of real importance.

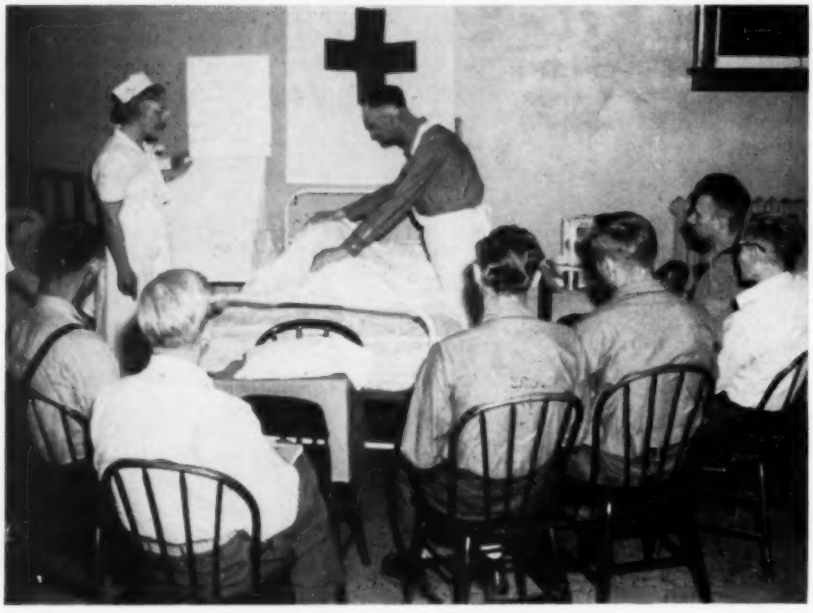
Ultimate Bed Capacity Limited

(11) The maximal amount of unassigned space compatible with the budgetary limitations of the project should be provided in each bed-containing building. The wisdom of this approach lies in our recognition of the rapid and inevitable changes to be expected in medical practice. It is a sensible insurance policy which will retard the obsolescence of the structure. The space should be usable at any time without the necessity of major structural additions or modifications and should never be so located that a future administration might be tempted to use it for additional beds. The conventional utilities should be roughed in, but areas of this kind should not be partitioned or otherwise finished. The most logical potential space is, of course, in basements. Grade contours often are such that full height windows fully above grade can be specified for extensive basement areas. Although floors remain below grade, the resulting space can be light, airy, cool in the summer and comfortably warm in the winter and can, with minimal expenditure, be used for laboratories, offices, lounge rooms, and treatment clinics.

(12) A firm upper limit for the ultimate bed capacity of the hospital as a whole should be clearly established at the time of the initial planning and inflexibly adhered to throughout the life of the institution. This is, of course, a principle which can be easily challenged by legislators and the uninformed public. Each of us is mournfully aware of the certain consequences of deviation from this practice. It is my thesis that the predictably unhappy consequences of adherence to it will be, at worst, a great deal less troublesome. With anticipatory vigilance on the part of professional people and effective liaison with the public, they can, I believe, be avoided.

(13) Facilities for training programs and research activities, even though modest in the extreme, should be provided in all hospitals, although no such functions may be projected at the time of construction. I can cite as an example of the desirability of this course the overnight reversal in philosophy of Veterans Administration hospitals, where, suddenly, provisions had to be made for a great number of academically sponsored resident training programs. It might not be altogether facetious to wonder whether the presence of the few unused classrooms or an extra laboratory or two might not, in time, silently nag a superintendent or a clinical director into setting up a program.

(14) Recognition should be given to the fact that the hospital will be the permanent home of a varying number of the staff. Although there is a marked tendency in some hospitals to urge that personnel live off the grounds, I doubt that it will ever be possible to staff a public mental hospital without providing living accommodations for certain employees. Thought given to their comfort and their privacy, to recreational facilities which are theirs alone, to eating places and such conveniences as barber and beauty shops, tailoring establishments, and postal service will have important implications in recruitment and turnover of personnel.



Left: The Red Cross instructor directs as a man patient practices one of the procedures learned in the home nursing course given for convalescent patients at Fergus Falls State Hospital.

Red Cross Teaches Home Nursing To Patients

By ALVINA LUTHER
Patient Program Supervisor
Fergus Falls (Minn.) State Hospital

Soon after the New Year in 1954, our hospital was contacted by area supervisors and the local chapter of the American Red Cross, offering to give a home nursing course to patients selected by the staff. The Chapter had a qualified instructor ready to go to work.

Our first question was: "Would the patients be interested and consider it valuable enough to complete the entire course?" We met with the patients' council of the convalescent ward to learn whether they wished to have us accept this volunteer service from the Red Cross. Printed material on the course was left with them. The council returned a very favorable decision and so we proceeded.

A notice was placed on the ward bulletin board and all those interested were asked to sign their names. About twenty-five men and women signed the list. The instructor, Mrs. H. J. Henning, moved her equipment into the classroom used by the psychiatric aides. Old newspapers, cardboard boxes, and the like, were gathered as part of the necessary equipment.

Mrs. Henning was taken to the ward to be introduced to the patients who had signed up for the course. The men were disappointed when we told them that the first course would be for women only, as the instructor preferred having the class confined to one sex. But we assured the men that as soon as the women's classes were completed there would be another course given for men. Nine women attended the first session. Classes were held from seven to nine, two evenings a week. The entire course was completed by eight women, in three weeks, whereupon graduation was held and they received Red Cross certificates and pins. The course was then repeated, as promised, for the men patients. All ten who started were graduated.

Two Jobs Result

Two patients, a man and a woman, were able to utilize the training after discharge from the hospital. The woman obtained a full-time job in a home for aged; the man took a part-time job in a general hospital as an orderly. The other patients have made general use of the information on the wards.

The course included proper making of beds, serving of food, taking temperatures, giving baths, disposing of wastes, improvising equipment, applying compresses and hot water bottles, giving enemas, making the patients comfortable in bed and in a chair, giving medicines, and the like.

The patients were particularly interested in learning how to improvise sickroom equipment, such as making a shawl from long towels, a robe from a blanket, funnels from heavy paper. One patient felt it would have been valuable to learn also about household chemistry, nutrition, and bacteriology, and about the correct handling of fractures and sprains until a doctor comes.

The course has better enabled these patients to look after themselves and to help others who are sick in bed. They give baths, apply hot compresses and do other small nursing chores they learned in the Red Cross course. On this open convalescent ward the nurse leaves at three p.m., after which supervision is supplied by periodical rounds by personnel from an adjoining ward. These patients feel better prepared to cope with any emergency situation that might arise on the ward.

The patients have become more inquisitive about the nature of physical illness and frequently have lengthy discussions on such topics as varying temperatures. One woman was sufficiently interested to further her knowledge by reading a book on practical nursing.

Advantages Commended

Comments gathered from patients, ward personnel, student nurses, instructors and social workers showed that both patients and personnel at the hospital think the course most valuable for convalescent patients. They feel that it is gratifying to patients to know they have an opportunity to take such a course during their hospitalization.

A similar course is now under way for long-term open ward women patients who are not undergoing electroshock therapy. We believe it will help these patients to perform housekeeping chores more efficiently, both on their own ward and in industrial therapy assignments.

DEPARTMENTS

Equipment

NEW TYPE OF BED ATTRACTIVE AND STURDY

A new type of bed for use in psychiatric hospitals has been designed by Dr. William C. Gaebler and his staff at the Metropolitan State Hospital in Waltham, Massachusetts. The ends are made of 1½" stainless steel tubing, 18 gauge in thickness, and are formed in rectangles with rounded corners. Head and foot ends are identical. Specially reinforced spring frames are equipped with no-sag type springs. The springs can be attached to the ends so that the fabric is either 22" from the floor, or, by inverting the ends, 9" from the floor.

The beds have been subjected to severe tests in the children's unit and have proved quite satisfactory. Up to this time there has been no destruction of the beds.

Those who have seen them have been favorably impressed with their appearance and sturdiness.

Those interested in the beds may inquire of Edward H. Kornhauser and Associates, New York City.

DR. THADDEUS P. KRUSH,
Gaebler Children's Unit,
Metropolitan State Hospital, Mass.

Chaplaincy

N. J. INSTITUTE GIVES COURSE FOR MINISTERIAL STUDENTS

The New Jersey Neuro-Psychiatric Institute is extending its program of training and service to the community through a course for theological students and ministers from Princeton Theological Seminary. The Institute, just six miles from Princeton, invites fifteen students to spend a half day each week for ten weeks at the institute to receive this training. The course is repeated three times a year, a total of about forty-five students completing the work each year. The students receive three hours academic credit from the Seminary for the course. Under the direction of the Resident Chaplain at the Institute, the group listens to lectures on personality development, case histories, group therapy and allied topics by physicians, psychologists and social workers. The students see films on mental health subjects, visit assigned patients, and participate in lively discussions of the problems arising out of the lectures and ward visits. They also transcribe accounts of several interviews with patients, and these are read by the Chaplain, who makes comments on counseling procedures and allied points. The Chaplain has had extensive special training for the institutional ministry.

This course has greatly increased interest in the relation between psychiatry and religion, the work of the medical therapist and the spiritual advisor. The Institute is the main source at this time for Princeton ministerial students to get practical instruction during the academic year on the problems of working with the emotional difficulties of people. One student described the course as "one of the most popular at the Seminary", and went on to say that many more students had tried to enroll than the facilities of the Institute could provide for. The demand is so great, in fact, that the Seminary plans to secure help of other institutions in the area which have qualified chaplains.

The brief course also stimulates future ministers to enroll in the twelve-week intensive course in Clinical Pastoral Training under the auspices of the Council for Clinical Training.

Community Relations

STATE HOSPITAL ASSISTS WITH ORTHOPEDIC CLINICS

For many years the Office of Services for Crippled Children of the Nebraska Division of Public Welfare has held extension clinics throughout the state to provide pediatric and orthopedic services in the various communities. The program is conducted in cooperation with the Nebraska Elks Association. The day-long clinics are held in whatever suitable facilities are available, usually in community hospitals, Elks, clubhouses, high schools, town halls and the like.

Norfolk State Hospital, located in the northeastern part of the state, has for the past twelve years made its facilities available to the clinics held in that area. Several times a year the hospital gives over examining, waiting and dining room space, and provides X-ray service. The hospital's medical and nursing staff do not participate other than to help with preliminary arrangements. The professional services for the clinics are provided without charge by specialists from Omaha and Lincoln.

Members of the local Elks Club, their wives, and Red Cross Gray Ladies help with registration and reception and provide transportation to and from train and bus depots. The Elks Club provides catering service for lunch.

Dr. C. G. Ingham, the superintendent, feels that his hospital's participation in this cooperative effort has been rewarded with greater interest in the hospital on the part of individuals and civic groups.

News & Notes

VA Appoints Middleton as Chief Medical Director

The retirement of Vice Admiral Joel T. Boone, M.C., as Chief Medical Director of the Veterans Administration became effective on February 28th. Admiral Boone had headed the VA medical program since 1951 and retired for reasons of health. He served as White House physician for three Presidents—Harding, Coolidge and Hoover.

He is succeeded by Dr. William S. Middleton, Dean of the University of Wisconsin Medical School since 1935. Dr. Middleton's appointment began on the 1st of March.

Dr. Middleton, an overseas veteran of both World Wars, has been associated with the VA in various consultative capacities for a number of years. One of his special interests has been establishing association between the VA and leading medical schools.

Harvey V. Higley, Administrator of Veterans Affairs, said that Dr. Middleton is "exceptionally well qualified to provide the kind of leadership that will insure a continuation of top quality medical care of eligible veterans."

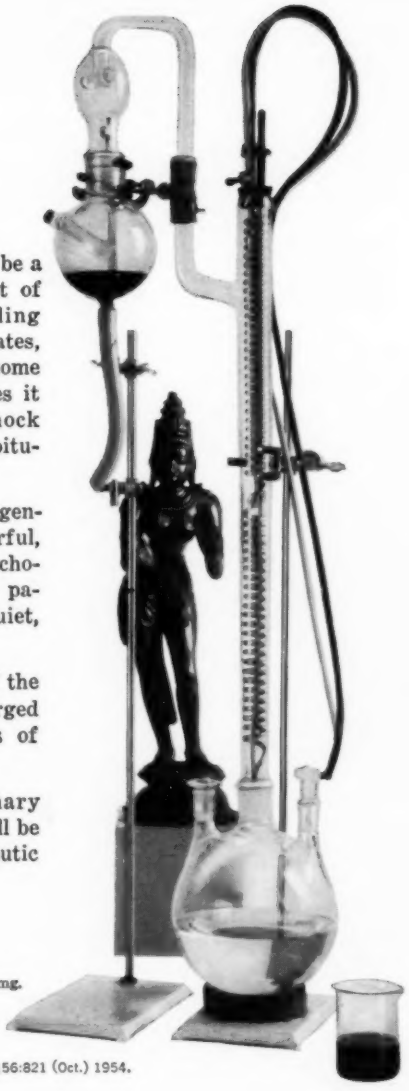
A NEW EMOTIONAL STABILIZER FOR NEUROPSYCHIATRIC THERAPY

Serpasil, in a recent study,[1] proved to be a valuable supplement in the treatment of neuropsychiatric conditions, including schizophrenia, paranoid and manic states, general paresis with psychosis and some cases of depression. In many instances it eliminated the need for electroshock therapy, restraints, seclusion and barbiturate sedation.

Combative, uncooperative patients in general became friendly, cooperative, cheerful, sociable and more amenable to psychotherapy under Serpasil. Hyperactive patients became sedate, noisy patients quiet, depressed patients alert.

Serpasil produced remissions in 20 of the 74 patients studied. Eight were discharged from the hospital. Long-term effects of treatment have not been determined.

If extended studies confirm preliminary findings, the authors state, Serpasil will be one of the most important therapeutic agents in the history of psychiatry.



Parenteral Solution (for psychiatric use only), 2.5 mg. Serpasil per ml., 2-ml. ampuls.
Tablets, 1.0 mg. (scored), 0.25 mg. (scored), 0.1 mg.
Elixir, 0.2 mg. Serpasil per 4-ml. teaspoonful.

1. Noce, R. H., Williams, D. B., and Rapaport, W.: J. A. M. A.: 156:821 (Oct.) 1954.

Serpasil®
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